Maryland Pediatric Cardiology Center Financial Policy Statement

Thank you for choosing our physicians for your healthcare needs. We are committed to providing the very best medical care and successful treatment. The following is a statement of our Financial Policy, which you must read, agree to, and sign, prior to treatment. Our Financial Policy applies to all service rendered by our physicians and staff, whether inpatient or outpatient.

Practice Payment Policy Guidelines:

Patients/guardians are financially responsible for all charges, regardless of third-party involvement.

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know your Insurance Coverage Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written Referrals, Pre-authorizations or Pre-certifications from their primary care physician or health plan prior-to services rendered. If we have not received the necessary authorizations prior-to their appointment, the appointment will be rescheduled. Please present both your Insurance and Picture ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patient with Private Insurance/Medicare/Medicaid Coverage: Our physicians participate with the Medicaid Program and most major insurance companies. However, we do NOT accept the Medicare program. We will file claim(s) to the insurance provided by yourself and authorized by your signature in the 'assignment of benefits' below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at the time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement: I understand that I am financially responsible for all charges regardless of a third-party involvement. I agree to pay any deductible, coinsurance, copayment, or services deemed as "non-covered" or "incidental" services by my insurance carrier, including, Emergency Prescription Refills or other convenience oriented care rendered. **I agree to pay $25.00 missed appointment fee for appointments cancelled with less than 24 hour notice**. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, and non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount due will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to 'collection', I agree to pay all collection costs, including, but limited to court costs, attorneys' fees equal to 33.33% of the amount owed, and accrued interest charges to date. **I agree to pay a $35.00 returned check fee**.

Authorization &Assignment of Insurance Benefits: I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronica or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical service rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agreed to the above policy.

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Patient/Responsible Party/Guardian Signature **Date**